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1-15174

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

2 1 1 8 2

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) LEONE MIDYETTE CHAPMAN			2a. DATE OF DEATH MONTH DAY YEAR July 26, 1986			2b. HOUR 1:44p. M			
3 SEX Female		4 RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR May 1, 1909		6 AGE (IN YEARS LAST BIRTHDAY) 77		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 77	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Queen Anne MD.			
10 CITY OR TOWN OF DEATH Centreville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Meridan Corsica Hills				12a. USUAL OCCUPATION (TYPE OF WORK FORMERLY OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	

13a. STATE Maryland			13b. COUNTY Talbot			13c. CITY OR TOWN St. Michaels			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Deep Water Point Rd. 21663		
14 FATHER'S NAME FIRST MIDDLE LAST John T. Midyette						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jessica Dunn								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 215-42-9706			17. INFORMANT ADDRESS Ryland O. Chapman II Long Haul Creek St. Michaels, Md. 21663								

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from July 86, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on July 86, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <i>Maurice Bienenfeld</i>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED July 26, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Maurice Bienenfeld				22e. ADDRESS Chestertown, Maryland 21620			

23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE July 29, 1986		23c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery		23d. LOCATION Smithfield Isle Of Wight County Virginia	
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24. FUNERAL DIRECTOR NAME <i>Shirley E. Leonard</i>		25a. DATE REC'D. BY REGISTRAR AUG 04 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Benson-Rodgers</i>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be called to the place of death.

BP

1. INTRODUCTION

The purpose of this study is to investigate the effects of various factors on the growth and development of the plant species studied.

2. MATERIALS AND METHODS

The study was conducted in a controlled environment. The plants were grown in pots containing a standard soil mixture. The experimental design included several treatments, each with a specific factor being manipulated. Data was collected over a period of six weeks, and the results were analyzed using statistical methods.

3. RESULTS

The results of the study show that the growth of the plants was significantly affected by the treatment factors. The plants in the control group showed the highest growth rate, while those in the treatment groups showed varying degrees of growth inhibition or promotion.

4. CONCLUSION

The study concludes that the treatment factors have a significant impact on the growth and development of the plant species studied. Further research is needed to determine the underlying mechanisms of these effects.

00-12442

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 2 1 1 8 3

1. DECEASED NAME (TYPE OR PRINT) CHARLES EARL LOFLAND			2a. DATE OF DEATH MONTH DAY YEAR JULY 6, 1986			2b. HOUR M				
3 SEX MALE		4 RACE CAUC.		5 DATE OF BIRTH MONTH DAY YEAR APR. 15, 1903		6 AGE (IN YEARS LAST BIRTHDAY) 83		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CLAYTON, DEL		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH QUEEN ANNES MD				
10. CITY OR TOWN OF DEATH CENTREVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERIDIAN NURSING CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER		12b. KIND OF BUSINESS OR INDUSTRY FARMING		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND			13b. COUNTY Q.A.		13c. CITY OR TOWN BARCLAY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RT. 1 BOX 25 A 21607	
14. FATHER'S NAME FIRST MIDDLE LAST FRANK LOFLAND			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DETTA COLE			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				
16b. SOCIAL SECURITY NO. 215-16-3813			17. INFORMANT DOROTHY YEAGER			ADDRESS MD 21636 MAPLE AVE. GOLDSBORO				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from June 17, 1986, to July 7, 1986, that (I) (we) last saw the deceased alive on July 7, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE John R. Smith, Jr.			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7/8/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Smith, Jr.			22e. ADDRESS Centreville MD 21617							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 7/9/86		23c. NAME OF CEMETERY OR CREMATORY TEMPLEVILLE CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE TEMPLEVILLE, CAROLINE, MD			
24. FUNERAL DIRECTOR NAME FELLOWS F.H.			ADDRESS BOX 270 MILLINGTON, MD 21658			25a. DATE REC'D. BY REGISTRAR JUL 15 1986		25b. REGISTRAR'S SIGNATURE John R. Smith, Jr.		

00-14637

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, no medical examiner visit is required.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8621184	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Nelson Davis					2a. DATE OF DEATH MONTH DAY YEAR July 27, 1986			2b. HOUR M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 25, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 23 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Queen Anne's County MD.					
10. CITY OR TOWN OF DEATH Centreville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Corsica Hills Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 100 South Kent St. 21620			
14. FATHER'S NAME FIRST MIDDLE LAST Jefferson Davis					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie Starkey						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-46-4663		17. INFORMANT Lola Everett		ADDRESS same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>several days</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>April 1</u> , 19 <u>77</u> , to <u>July 27</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>July 27</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>C. Gottfried Baumann</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>7/28/86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. Gottfried Baumann, M.D.				22e. ADDRESS Medical Building, Chestertown, MD 21620							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 07/30/86		23c. NAME OF CEMETERY OR CREMATORY Church Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Church Hill Q.A. MD					
24. FUNERAL DIRECTOR NAME Tom Helfenbein Funeral Homes, Church Hill, MD				25a. DATE REC'D. BY REGISTRAR 21623 AUG 7 1986		25b. REGISTRAR'S SIGNATURE <u>J. Davidson-Randall</u>					

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00-11508

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

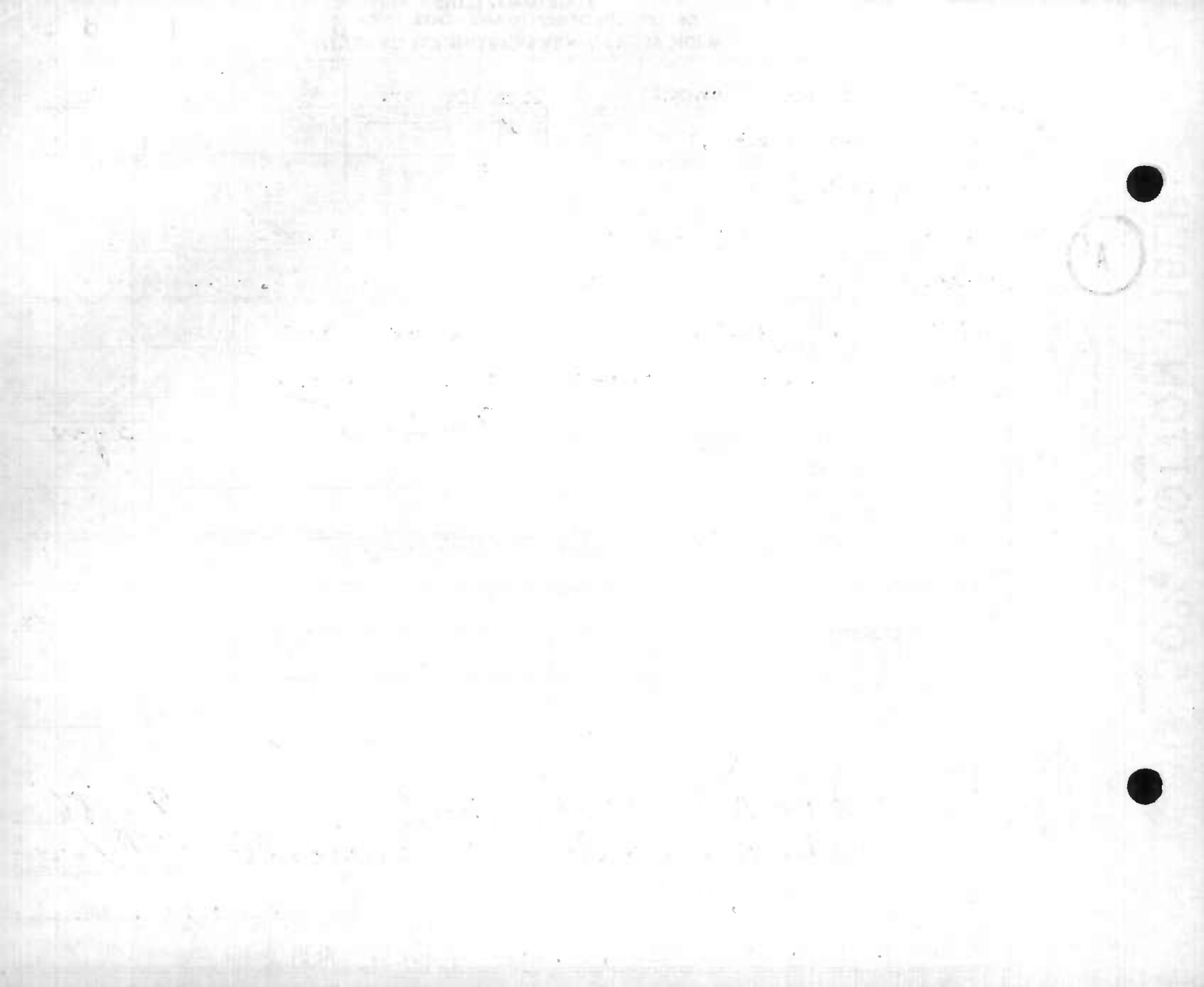
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF DEATH			2b. HOUR				
Richard Cornwall			Franklin			Sr.						<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> July 1 19 86			1 A M				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR				
Male		White		March 1, 1919		67 YRS.						July 1 19 86			A M				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED				9. BALTIMORE CITY OR COUNTY OF DEATH				MD.			
Washington, D.C.				USA				<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED				QUEEN ANNE'S							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
INGLESIDE				INGLESIDE NURSING HOME								MACHINIST				NAVY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																			
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS			
DELAWARE				SUSSEX				REHOBOTH BEACH				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				200 Estate Drive 19971			
14. FATHER'S NAME								15. MOTHER'S MAIDEN NAME											
RICHARD S. FRANKLIN								FLORENCE MARIE CORNWALL											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS											
YES				W.W.II				225-10-5290				WILIDINE E. FRANKLIN SAME AS #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																			
PART I DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) _____																			
DUE TO, OR AS A CONSEQUENCE OF _____																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. _____																			
(b) _____																			
DUE TO, OR AS A CONSEQUENCE OF _____																			
(c) _____																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?															
20a. AUTOPSY?																			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
				HOUR A.M. MONTH DAY YEAR															
				P.M. 19															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION											
								STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED											
John R. Smith				M.D. Dep't				7/1/86											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
John R. Smith				Centerville															
23a. BURIAL, CREMATION, REMOVAL				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION							
BURIAL				JULY 3, 1986				LAYTONSVILLE				LAYTONSVILLE MONT. MD.							
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
NAME ADDRESS				JUL 7 1986				Julia Davidson-Randall											
FRANCIS H. BARBER LAYTONSVILLE, MD. 20879																			

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DMH-17
(VR A15 ME (3))
30M 7/73



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 1 1 8 6

REG. NO.

1- FOR
STATE
REGISTRAR

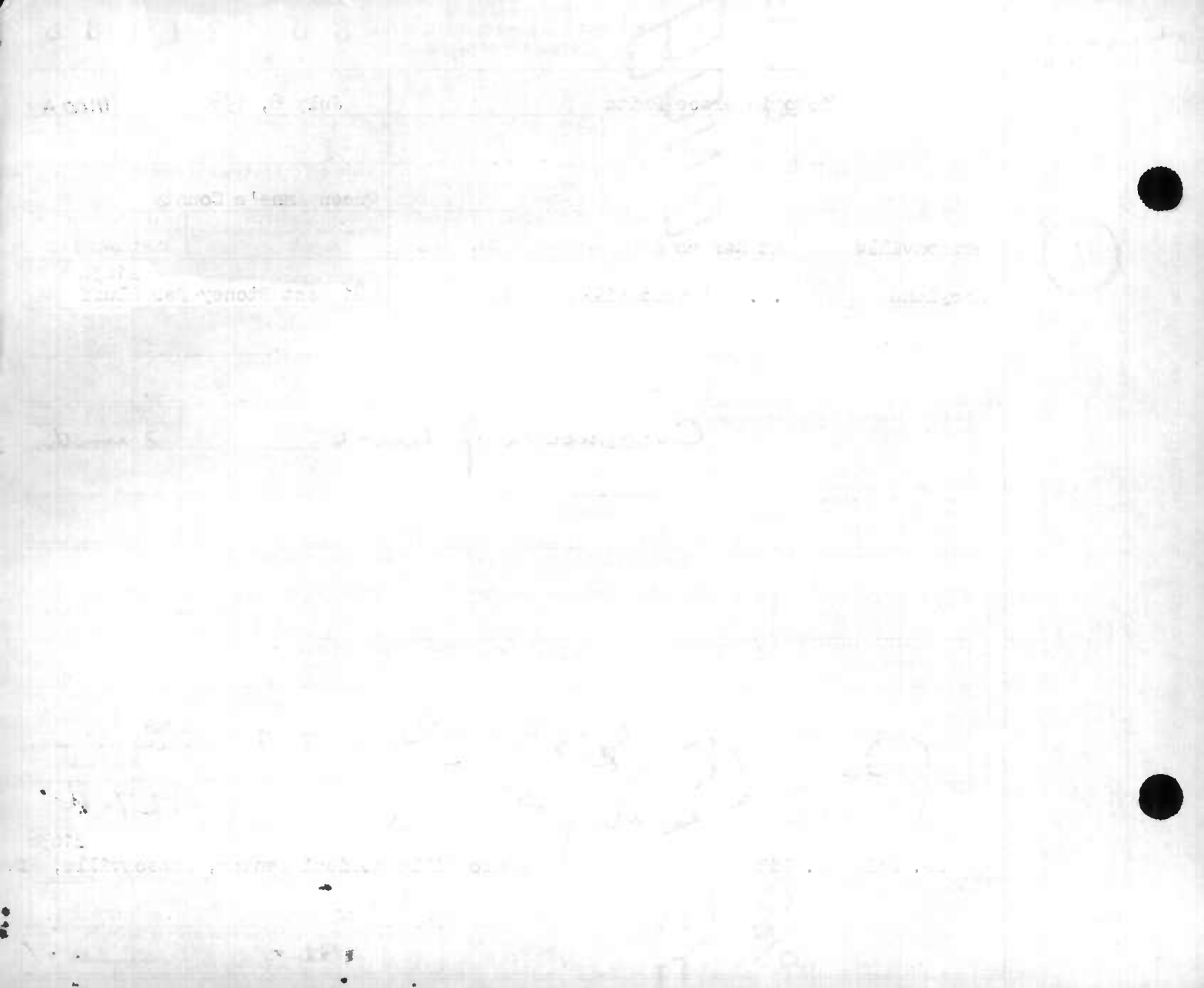
1. DECEASED NAME (TYPE OR PRINT) Victoria Grace Fritz			2a. DATE OF DEATH MONTH DAY YEAR July 6, 1986			2b. HOUR 11:00 A.M.			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Sept. 25, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hagerstown		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Queen Anne's County MD.			
10. CITY OR TOWN OF DEATH Grasonville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) at her home 81 E. Stoney Bar Bluff				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) cook		12b. KIND OF BUSINESS OR INDUSTRY restaurant	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / 710 COR 300 Cornell Avenue 21740	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Raymond Fritz				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth R. Sinn					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-14-9087		17. INFORMANT ADDRESS Alice I. Doud, Williamsport, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of liver</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>6-25</u> 19 <u>86</u> , to <u>7-7</u> 19 <u>86</u> , that (I) was lost saw the deceased alive on <u>7-1</u> 19 <u>86</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) can <u>did</u> not view the body after death.									
22b. SIGNATURE <u>Ralph E. Libby</u>			22c. DATE SIGNED <u>7-7-86</u>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Ralph E. Libby			
22e. ADDRESS Grasonville Medical Center, Grasonville, MD			22f. DATE SIGNED <u>7-7-86</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE July 10, 1986		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland		
24. FUNERAL DIRECTOR NAME 415 E. Wilson Blvd., Hagerstown, Md. 21740			MINNICH FUNERAL HOME ADDRESS		25a. DATE REC'D. BY REGISTRAR JUL 10 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be placed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____



0-14740

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM #1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 6 21187

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2d. HOUR	
CHARLIE ERSKIN MANLEY								JULY 28, 1986								1 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
MALE	CAUC.	JAN 1, 1937		49 YRS.						JULY 28, 1986						730 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
VIRGINIA		USA		WIDOWED		DIVORCED		QUEEN ANNE									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING YEARS)		12b. KIND OF BUSINESS OR INDUSTRY											
SUDLERSVILLE		RT 1 BOX 101 A STALLTOWN-BLANCA		PAINTER		SUB CONTR											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS		13e. STREET ADDRESS									
MARYLAND		Q.A.		SUDLERSVILLE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		STALLTOWN-BLANCA RD. 21668									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Leonard		G. Manley		Ruby		L. Ayers											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
no		217-36-0612		KATHERINE MANLEY wife		same											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
		Arterio sclerotic Cardiac vascular		DUE TO, OR AS A CONSEQUENCE OF													
		Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF											
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		7/30/86											
EXAMINER'S NAME (TYPE OR PRINT)		DR. ROBERT FARR		ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
BURIAL		7/31/86		DOUBLE CREEK CEM.		CRUMPTON, Q.A. MD											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
FELLOWS F.H. BOX 270 MILLINGTON, MD 21651				AUG 05 1986		Julia T. [Signature]											



00-13670

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGE 4 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										8 6 2 1 1 8 8 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Richard Lee Micken						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7-20 19 86		2b. HOUR M			
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 4 3 59	6. AGE (IN YEARS LAST BIRTHDAY) 27 YRS.	7. UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD 7-20 1986	2d. HOUR 12:05 A.					
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		9. CITIZEN OF WHAT COUNTRY? U.S.		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Queen Anne's County MD					
12. CITY OR TOWN OF DEATH Queenstown			13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Route 301-50, Queenstown			14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lab. Lbr		15. KIND OF BUSINESS OR INDUSTRY			
16. STATE Md.		17. COUNTY QA		18. CITY OR TOWN Georgetown		19. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. STREET ADDRESS Box P9 Georgetown, Md.			
21. FATHER'S NAME FIRST MIDDLE LAST Richard Brock				22. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marlene Wickens							
23. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		24. (IF YES, GIVE WAR OR DATES) 1979-1980		25. SOCIAL SECURITY NO.		26. INFORMANT ADDRESS Marlene Wickens					
27. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
28. DATE OF OPERATION			29. CONDITION FOR WHICH OPERATION WAS PERFORMED?					30. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
31a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			31b. TIME OF INJURY HOUR XX MONTH DAY YEAR 11:04 P.M. 7-19-86			31c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver in motor vehicle/motor vehicle collision					
32a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			32b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway			32c. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 301-50, Queenstown, Queen Anne's Co., Md.					
33. I certify that took charge of the remains described above, held death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		
34. ACTUAL SIGNATURE John E. Smialek			35. TITLE (SPECIFY) Chief			36. MEDICAL EXAMINER			37. DATE SIGNED 7/20/86		
38. EXAMINER'S NAME (TYPE OR PRINT) John E. Smialek, M.D.			39. ADDRESS 111 Penn St. Balto.MD.								
40. BURIAL, CREMATION, REMOVAL (SPECIFY) B			41. DATE 7/24/86		42. NAME OF CEMETERY OR CREMATORY Chester			43. LOCATION CITY OR TOWN COUNTY STATE Chester QA Md.			
44. FUNERAL DIRECTOR NAME Ernie L. Dashiell FH			45. ADDRESS P.O. Box 101 411			46. DATE REC'D. BY REGISTRAR JUL 25 1986		47. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

00-11915

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JESSIE LOUISE PRICE			2a. DATE OF DEATH MONTH DAY YEAR 07 01 86			2b. HOUR 12:35 P			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 11 16 07		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Queen Anne's County MD.			
12. CITY OR TOWN OF DEATH CENTREVILLE		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERIDIAN NURSING CENTER-CORSICA HILLS				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CAFETERIA WORKER		15. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOL	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE MARYLAND 16b. COUNTY KENT 16c. CITY OR TOWN Rock Hall				17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		18. STREET ADDRESS / ZIP CODE 26 S. Main Street 21661			
19. FATHER'S NAME FIRST MIDDLE LAST ROMIE HARRIS				20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kate RODNEY					
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		22. SOCIAL SECURITY NO. 218-16-9661		23. INFORMANT ADDRESS PAT EDLER Rt 2 Box 161 CHESTERTOWN, Md. 21620					
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>stroke</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>stroke</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>maturity onset diabetes</u>									
25. DATE OF OPERATION 9-1-86		26. CONDITION FOR WHICH OPERATION WAS PERFORMED		27. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
32. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		33. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		34. LOCATION STREET CITY OR TOWN COUNTY STATE					
35. I certify that (I) (this hospital) attended the deceased from <u>1961</u> , 19 <u>85</u> , to <u>7-1</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>6-30-86</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
36. SIGNATURE <u>Robert W. Farr</u>				37. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		38. DATE SIGNED 7/3/86			
39. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT W. FARR				40. ADDRESS Chestertown Md					
41. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		42. DATE 07/03/86		43. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cemetery		44. LOCATION CITY OR TOWN COUNTY STATE Rock Hall Kent MD			
45. FUNERAL DIRECTOR NAME Tom Helfenbein Funeral Home, Rock Hall, MD 21661				46. DATE REC'D. BY REGISTRAR JUL 9 1986		47. REGISTRAR'S SIGNATURE <u>J. H. Henderson</u>			

MEDICAL CERTIFICATION

2

9

1

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

0-13110

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 1 1 9 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR					
William Donald Smith			July 17, 1986			10:30am					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR			
Male		White		02-25-19		67 YRS		MONTHS DAYS HOURS MIN.			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. CITIZEN OF WHAT COUNTRY?		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Queen Anne's County MD.					
12. CITY OR TOWN OF DEATH		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		15. KIND OF BUSINESS OR INDUSTRY			
Stevensville		at his home				Motorcycle Mechanic					
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			17. 13a. STATE			18. 13b. COUNTY			19. 13c. CITY OR TOWN		
MA Maryland			Q.A.			Stevensville			YES <input type="checkbox"/> NO <input type="checkbox"/>		
20. FATHER'S NAME (TYPE OR PRINT)			21. MOTHER'S MAIDEN NAME			22. STREET ADDRESS / ZIP CODE			23. 106 North Lake Drive 21666		
Charles R. Smith			Gladys Unknown								
24. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			25. SOCIAL SECURITY NO.			26. INFORMANT			27. ADDRESS		
Yes			WWII			220-03-0375A			Dorothy Smith same as above		
28. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Esophageal cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Cirrhosis of Liver</u>											
29. DATE OF OPERATION			30. CONDITION FOR WHICH OPERATION WAS PERFORMED			31. AUTOPSY?			32. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
33. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			34. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			35. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
36. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			37. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			38. LOCATION STREET CITY OR TOWN COUNTY STATE					
39. I certify that (I) (this hospital) attended the deceased from <u>6 1/2</u> years of care, 19 <u>86</u> , and that in my opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
40. SIGNATURE <u>Anthony Calabrese</u>			41. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			42. DATE SIGNED 7/17/86					
43. PHYSICIAN'S NAME (TYPE OR PRINT) A. J. CALABRESE, M.D.			44. ADDRESS 171 Defense Highway, Annapolis, MD 21401								
45. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			46. DATE 07/17/86			47. NAME OF CEMETERY OR CREMATORY Security Process			48. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balt. MD		
49. FUNERAL DIRECTOR NAME Tom Helfenbein Funeral Home, Chester, MD 21619			50. ADDRESS			51. DATE REC'D BY REGISTRAR JUL 22 1986			52. REGISTRAR'S SIGNATURE Jana Davidson		

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, only the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT) If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

001110



BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use on the burial-transit permit. Then please make a copy of this certificate and attach it to the certificate of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.
IMPORTANT: If item 21 is marked as true, it shows any injury, or other traumatic event, the medical examiner must be notified of and

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 6 2 1 1 9 1	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Henry N/A Wright			2a. DATE OF DEATH MONTH DAY YEAR June 26 1986		2b. HOUR 8:15 P.
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR Dec. 26 1999	
6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		8. CITIZEN OF WHAT COUNTRY? U.S.A.	
9. BALTIMORE CITY OR COUNTY OF DEATH Queen Anne MD.		10. CITY OR TOWN OF DEATH Centreville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Corsica Hills Nursing Center	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor		12b. KIND OF BUSINESS OR INDUSTRY Farming		13. STREET ADDRESS / ZIP CODE 21651 Spring Rd. Millington, Md.	
14. FATHER'S NAME FIRST MIDDLE LAST John Smith		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Wright Smith		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
17. INFORMANT ADDRESS Elizabeth Wright Same As Above		18. SOCIAL SECURITY NO 214-32-0501		19. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5-12</u> , 19 <u>86</u> , to <u>6-26</u> , 19 <u>86</u> that (I) (we) lost saw the deceased alive on <u>6-26</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and I am the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Robert W. Farr</i>				22c. DATE SIGNED 7-8-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Farr, M.D.				22e. ADDRESS Chestertown, Maryland 21620	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-1-1986		23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cem.	
24. FUNERAL DIRECTOR NAME Fellows Funeral Home, Millington, Md.		23d. LOCATION CITY OR TOWN Pondyown		23e. COUNTY Q.A.	
25a. DATE REC'D. BY REGISTRAR JUL 15 1986		25b. REGISTRAR'S SIGNATURE <i>Felix Davidson-Randall</i>		25c. STATE Md.	

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